Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004016	A. BUILDING: _____ B. WING _____	C 07/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE PLACE	2770 S ADAMS RD BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00152363. Complaint IN00152363 - Unsubstantiated due to lack of evidence. Survey date: July 29,2014 Facility number: 004016 Provider number: 004016 AIM number: N/A Survey team: Susan Worsham, RN, TC Census bed type: Residential: 58 Total: 58 Census payor type: Medicare: n/a Medicaid: n/a Other: 58 Total: 58 Sample: 03 Monroe Place was found to be in compliance with 410 IAC 16.2 -5 in regard to the Investigation of Complaint IN00152363. Quality Review 07/30/14 by Lisa McColly	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE